STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand River Health Care	118 Trenton Road Chillicothe, MO 64601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to protect one resident (Resident #1) from abuse on 01/05/26, when the Director of Nursing (DON) and the Administrator forced the resident to remove soiled clothing by physically restraining the resident's arms, hands, and ripping the soiled clothing off while the DON yelled curses and obscenities at the resident. As a result, the resident complained of arm pain and said they hurt me. Multiple, small, light-colored bruises were observed. The resident was transported to the emergency room for evaluation. The facility also failed to provide continued protection when the DON and Administrator were not immediately removed from the facility, per policy, and they continued to provide oversight for all residents until 01/06/26. The facility census was 31.The administrator was notified on 01/08/26 at 1:22 P.M. of an Immediate Jeopardy (IJ) which began on 01/05/26. The IJ was removed on 01/08/26 as confirmed by surveyor on-site. Review of the facility policy titled, Abuse Prohibition Protocol Manual, dated 11/28/16 showed: -It is the policy of the facility that each resident will be free from verbal, mental or physical abuse and corporal punishment; -Residents will be protected from abuse, neglect and harm while they are residing at the facility;-No abuse or harm of any type will be tolerated; -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; -Examples of physical abuse include: hitting, scratching, holding someone down, grabbing a resident by arms or legs;-All employees are mandated reporters; -All employees who have been alleged to commit abuse will be suspended immediately pending investigation. Review of Resident #1's Quarterly Minimum Data Set (MDS: a federally mandated assessment completed by facility staff) dated 09/23/25 showed:-He/She had cognitive loss; -He/She was able to make his/her needs and wants known; -He/She needed maximum assistance of staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);-He/She was always incontinent of bowel and bladder; -He/She had verbal and physical behaviors (such as yelling, kicking, screaming, hitting) 4-6 days of a 7 day period; -Diagnoses included: Mood disorder (a mental health condition causing extreme, persistent emotional shifts such as sadness, elation and anger, that disrupt daily life), violent behaviors, diabetes, anxiety, depression, Parkinson's (a progressive brain and nerve disorder that effects movement, thought and body function), and dementia. Review of the resident's Comprehensive Care Plan dated 12/23/25 showed: -He/She exhibited verbal and physically abusive behavioral symptoms towards staff during cares, such as yelling, cursing, resisting care, hitting, kicking, pinching others; -The staff were supposed to avoid power struggles with the resident; -The staff were supposed to explain all procedures; -The staff were supposed to maintain a calm, slow, understandable approach with the resident; -When the resident becomes verbally abusive, STOP and try the task later; -Do not force the resident to do the task;-Allow the resident to have control over situations, if possible; -Allow the resident to make decisions.During an interview on 01/07/26 at 1:40 P.M., the Maintenance Director/Nurse Aide (NA) A said: -He went to assist Resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1 to change a soiled brief and clothing on 01/05/26 at about 1:44 P.M.; -The resident did not want a female Certified Nurse Aide (CNA) Z in his/her room and yelled at CNA Z to get out; -CNA Z left the room and Maintenance Director/NA A started to assist the resident to roll to the side to get changed; -The DON walked into the room, told the resident he/she needed to get cleaned up; -The resident yelled at the DON to get out and leave him/her alone; -The Maintenance Director/NA A got the resident to agree to allow the DON to help him/her turn over in bed only; -The DON pulled on the resident; -The resident said it hurt and the DON told the resident he/she was fine and there was nothing wrong with him/her; -The resident was pulling and smacking at the DON, the DON let go of the resident's arms and the resident rolled to his/her back; -The Maintenance Director/ NA A applied a clean brief; -He/She noticed the resident's shorts were heavily soiled and asked the resident if the shorts could be changed; -The resident agreed to allow the Maintenance Director/ NA A to change them; -He/She told the resident he/she needed to check the laundry and would return; -The DON began grabbing and pulling on the resident's shorts; -The resident grabbed onto his/her shorts with one hand, began yelling for the DON to get out and leave him/her alone; -The resident began slapping at the DON with the other hand; -The Maintenance Director/NA A stepped away from the bedside; -The Administrator walked into the resident's room; -The DON told the Administrator/Certified Medication Technician(CMT)/Certified Nurse Assistant (NA) to grab the resident; -The Administrator grabbed the resident by the hand and the elbow and held his/her arm tightly; -The resident was kicking and screaming; -The resident kicked toward the DON's face; -The DON said kick me again motherfucker and see what happens; -The Maintenance Director/NA A told the Administrator and DON to stop and leave the resident alone, and he/she wanted nothing to do with it; -The Administrator told the Maintenance Director/ NA A to hold the resident's arms; -The Maintenance Director/NA A refused and he/she left the resident's room; -The Maintenance Director/NA A left the facility; -He/She was not sure who to report to, because normally he/she would report to the DON or Administrator, but it was them abusing the resident; -He/She was taking CNA classes and knew holding someone by the arm, cursing them and ripping their shorts off, when they do not want you to, was abuse; -He/She reported the event to the Social Service Director (SSD) the morning of 01/06/26 and the SSD told him/her call the abuse hotline to report it; -Resident #1 had some small bruises on his/her arms on 01/06/26 that he/she did not see during bathing the day before. During an interview on 01/09/26 at 10:53 A.M., the DON said:-She went to assist the Maintenance Director/NA A with the resident as she could hear the resident yelling in the next room; -She and the Maintenance Director/NA A got the resident changed into a clean brief; -She asked the resident to change his/her shorts and he/she said no; -The Administrator entered the room and went to the resident's left side; -She put her hands on the resident's shorts, and proceeded to attempt to pull them off, the resident had hold of his/her shorts with one hand and began hitting with the other hand; -The resident grabbed the Administrator's hand and kicked at the DON; -She would expect if the resident becomes combative, staff are to leave the resident and try again later; -She didn't leave the resident alone, because his/her shorts were heavily soiled; -The resident had a clean brief on; -The resident had daily behaviors of hitting, kicking, yelling; -She did not curse at the resident; -The resident cursed at her.During an interview on 01/10/26 at 10:50 A.M., the Administrator said:-She entered the resident's room on 01/05/26 as she could hear the resident yelling; -The resident was upset about his/her shorts being changed; -The resident said to leave him/her alone;-The resident had hold of his/her shorts; -The DON held the resident's shorts with one hand; -The resident had on a clean brief; -The resident was hitting and kicking; -She did not grab the resident's arm, but her hands were on the resident's arm; -She and the DON got the resident's shorts off, covered the resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	up and left the room; -She was paying attention to the resident and not what the DON was doing to the resident's shorts:-She would expect staff to use appropriate approach; -There are approaches that work easier for the resident; -She would expect staff to leave the resident, if behaviors occurred, and get help; -She would do things differently from the very beginning and started the interaction differently; -When the resident became combative again she and the DON covered him/her up and left the room. During an interview on 01/07/26 at 2:31 P.M., the SSD said:-She heard the resident yelling and went to his/her room to investigate; -When she arrived in the hall outside the resident door, the Business Office Manager (BOM) was standing in the hallway; -She stayed outside the door as she could hear the DON's voice from the resident's room; -She heard the DON say kick me again motherfucker and see what happens; -The resident's room door opened, the Maintenance Director/NA A exited, and said he/she did not want any part of this; -She remained in the hall because the DON and the Administrator, who was her boss, were in the room and she did not think anything bad could be happening;-The next morning it was reported to her the resident wanted to call the police; -She asked the Maintenance Director/NA A what had occurred the day before; -He/She reported the Administrator held the resident down by the arm and the DON cursed at the resident and ripped off the resident's shorts; -She was not sure where to go since the allegations were against their bosses; -The SSD said when the MDS Coordinator (MDSC) came in on 01/06/26 she reported the incident to her because she knew the MDSC also had an Administrator license; -The MDSC instructed them to call the DHSS hotline;-She went to talk with the resident, he/she would not let her shake his/her hand, and reported his/her hand hurt, and he/she wanted to move closer to the nurses station for safety; -At the time of hire, three weeks ago, the SSD watched a video on abuse; -The video said to report to the Administrator, but did not tell her what to do if the Administrator was the perpetrator; -Multiple residents had complained of the Administrator being rude and hateful, but he/she was instructed by the Administrator not to file formal grievances. During an interview on 1/6/26 at 3:10 P.M., the BOM said:-She worked at the facility since September 2025; -On 01/05/26 she walked down the hall to find the Administrator, and could hear yelling from the resident's room; -She heard the DON yell the f word' but was unsure of anything else that was said as a staff member was in the hall talking; -The Maintenance Director/NA A exited Resident #1's room and said he/she wanted no part of this, and walked away; -On 01/06/26 a staff member asked her how to file a grievance against the Administrator, she was unsure, and told the staff member she would have to check; -When the MDSC came in to work, she asked her what needed to be done, and then the Maintenance Director/NA A entered and told the MDSC what had happened 01/05/26 with the resident; -She watched a video on abuse when she started; -The video said to report to the Administrator, but did not tell staff what to do if the alleged perpetrator was the Administrator; -She talked with the resident on 01/06/26 and he/she complained of arm pain; -The resident did not normally complain of arm pain, that the BOM was aware of. During an interview on 1/7/26 at 4:20 P.M., the Acting Administrator/MDSC said:-She was filling in for the MDSC as the facility did not have a current one; -She entered the facility on the morning of 01/06/26 and was approached by the SSD and BOM about the situation of the resident possibly being abused; -She notified the Director of Operations and began an investigation; -She called the DON and suspended her, and told the Administrator she was suspended when she came into the building; -The corporate reporting line was posted on the bulletin board, along with DHSS hotline number; -She was unsure why staff did not know about the phone numbers that were posted; -She would expect staff to report alleged abuse to the Administrator, if the Administrator was involved she would expect them to call the corporate line; -It was not appropriate for anyone to curse or hold the resident down; -The resident had a history of verbal and physical (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behaviors, but those lessen when he/she is approached correctly; -The Maintenance Director/NA A had a good rapport with the resident, and was in CNA classes.During an interview and observation on 01/07/26 at 1:25 P.M., the resident said:-His/Her arms hurt;-He/She would not allow his/her arm to be looked at. Review of the resident's right arm and hand x-ray dated 01/06/26 showed there were no fractures Observation on 01/07/26 at 2:13 P.M., showed:-Resident #1 had dime sized round light-yellow discoloration to inner left forearm, dime size light yellow discoloration on the hand below the thumb and a dime sized light yellow discoloration to inner left right forearm; -He/She said they hurt me here using his/her right hand to indicate his/her left arm. At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation.Intake 2709806Intake 2708966

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to immediately report an allegation of abuse to the state survey agency. This effected one of four sampled residents (Resident #1). The facility census was 31.Review of the facility policy titled, Abuse Prohibition Protocol Manual, dated 11/28/2016 showed: -It is the policy of the facility that each resident will be free from verbal, mental or physical abuse and corporal punishment; -Residents will be protected from abuse, neglect and harm while they are residing at the facility;-No abuse or harm of any type will be tolerated; -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; -Examples of physical abuse include: hitting, scratching, holding someone down, grabbing a resident by arms or legs;-All employees are mandated reporters; -The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements; -All allegations of abuse, will be reported immediately, but no later than the following time frames: If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made. If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours. Review of Resident #1's Quarterly Minimum Data Set (MDS: a federally mandated assessment completed by facility staff) dated 9/23/25 showed:-He/She had cognitive loss; -He/She was able to make his/her needs and wants known; -He/She needed maximum assistance of staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);-He/She had verbal and physical behaviors (such as yelling, kicking, screaming, hitting) 4-6 days of a 7 day period; -Diagnoses included: Mood disorder (a mental health condition causing extreme, persistent emotional shifts such as sadness, elation and anger, that disrupt daily life), violent behaviors, diabetes, anxiety, depression, Parkinson's (a progressive brain and nerve disorder that effects movement, thought and body function), and dementia. During an interview on 01/07/26 at 1:40 P.M., the Maintenance Director/Nurse Aide said: -He was assisting the resident with a brief change (01/05/26); -The Director of Nursing (DON) entered the room and told the resident he/she needed to get cleaned up; -The resident yelled at the DON to get out and leave him/her alone; -The Maintenance Director convinced the resident to allow the DON to help him/her turn over only; -The DON pulled on the resident; -The resident complained it hurt; -The DON told the resident he/she was fine and there was nothing wrong with him/her; -The resident began yelling and smacking at the DON; -The DON let go of the resident; -The Maintenance Director saw the resident's shorts were heavily soiled and got the resident to agree to be changed; -The DON began grabbing and pulling on the resident's shorts, the resident grabbed onto the shorts with one hand, and began yelling for the DON to leave him/her alone; -The resident began slapping at the DON with the other hand; -The Maintenance Director stepped away from the resident's bedside; -The Administrator entered the resident's room; -The DON told the Administrator to grab the resident; -The Administrator grabbed the resident by the hand and the elbow and held his/her arm tightly; -The resident was kicking and screaming; -The resident kicked toward the DON's face; -The DON said kick me again motherfucker and see what happens; -The Maintenance Director told the Administrator and DON to stop and leave the resident alone, and he wanted nothing to do with it; -The Administrator told the Maintenance Director to hold the resident's arms; -The Maintenance Director refused and he/she left the resident's room; -The Maintenance Director left the facility; -The Maintenance Director was not sure who to report to, because normally he/she would report to the DON or Administrator, but it was them abusing the resident; -The Maintenance Director was taking Certified Nurse Aide (CNA) classes and knew holding someone by the arm, cursing them, and ripping their shorts off, when they do not (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	want you to, was abuse; -He reported the event to the Social Service Director (SSD) the morning of 01/06/26 and the SSD told him/her call the abuse hotline to report it; -The resident had some small bruises on his/her arms on 01/06/26 that he/she did not see during bathing the day before.During an interview on 01/07/26 at 2:31 P.M., the SSD said:-She heard the resident yelling and went to his/her room to investigate; -When she arrived in the hall outside the resident door, the Business Office Manager (BOM) was standing in the hallway; -She stayed outside the door as she could hear the DON's voice from the resident's room; -She heard the DON say kick me again motherfucker and see what happens; -The resident's room door opened, the Maintenance Director exited, and said he/she did not want any part of this; -She remained in the hall, because the DON and the Administrator, who was her boss, were in the room and she did not think anything bad could be happening;-The next morning it was reported to her the resident wanted to call the police; -She asked the Maintenance Director what had occurred the day before; -He/She reported the Administrator held the resident down by the arm and the DON cursed at the resident and ripped off the resident's shorts; -She was not sure where to go since the allegations were against their bosses; -When the MDS nurse came in on 01/06/26 she reported the incident to her, because she knew the MDS nurse also had an Administrator license; -The MDS nurse instructed them to call the DHSS hotline;-At the time of hire, three weeks ago, she watched a video on abuse; -The video said to report to the Administrator, but did not tell her what to do if the Administrator was the alleged perpetrator. During an interview on 01/06/26 at 3:10 P.M., the BOM said:-She worked at the facility since September 2025; -On 01/05/26 she walked down the hall to find the Administrator and could hear yelling from the resident's room; -She heard the DON yell the f word', but was unsure of anything else that was said as a staff member was in the hall talking; -The Maintenance Director exited Resident #1's room and said he/she wanted no part of this, and walked away; -On 01/06/26 a staff member asked her how to file a grievance against the Administrator, she was unsure, and told the staff member she would have to check; -When the MDS nurse came in to work, she asked her what needed to be done, and then the Maintenance Director entered and told the MDS nurse what had happened 01/05/26 with the resident; -She watched a video on abuse when she started; -The video said to report to the Administrator, but did not tell staff what to do if the alleged perpetrator was the Administrator. During an interview on 01/07/26 at 4:20 P.M., the Acting Administrator/MDS nurse said:-She entered the facility on the morning of 01/06/26 and was approached by the SSD and BOM about the situation of the resident possibly being abused; -She notified the Director of Operations and began an investigation; -She called the DON and suspended her, and told the Administrator she was suspended when she came into the building; -The corporate reporting line was posted on the bulletin board, along with DHSS hotline number; -She was unsure why staff did not know about the phone numbers that were posted; -She would expect staff to report alleged abuse to the Administrator, if the Administrator was involved she would expect them to call the corporate line.Intake 2709806Intake 2708966